U. S. S E N A T E

Republican Policy Committee

Don Nickles, Chairman Doug Badger, Staff Director 347 Russell Senate Office Building (202)224-2946 http://www.senate.gov/~rpc/

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Applying Individual Savings Accounts to Health Care

Medical Savings Accounts: Reform that Works

Perhaps the most discussed aspect of the current health care debate is the Medical Savings Account (MSA) proposal. Yet, MSAs should hardly be looked upon as controversial: they're in use in many states, and — until very recently — were widely supported on both sides of the political aisle. The MSA approach is not new, but is simply following the path innovation so often takes by combining existing methods to a more refined practice.

Giving favorable tax treatment for the use of individual savings accounts dedicated to a specific purpose long has been a fixture of our tax code: it's been allowed for retirement purposes for some time. Such savings accounts for medical purposes — MSAs — are already being used in 17 states. An MSA proposal may be offered as an amendment to the Kassebaum-Kennedy health care bill (S.1028). It would allow for the establishment of individual savings accounts dedicated to health care spending by granting them equitable treatment in the tax code.

Despite the widespread use of MSAs by states and the familiarity of the Individual Retirement Account (IRA), the MSA proposal in Congress is being resisted by those who have liked them at other times and in other places. The MSA idea is innovation that has worked in other contexts and will work at the national level in American health care, too.

MSA: Tax-Deductible Savings Account

MSAs are basically IRAs, which — instead of being earmarked for retirement — must be used for health care expenses. The individual or family would purchase a high-deductible plan and then use the money they had accumulated in their savings account, up to the deductible limit, for health care expenses. Money in the MSA would earn tax-free interest and could be carried over to future years.

As provided for in both the Balanced Budget Act (which Congress passed and President Clinton vetoed) and H.R. 3103, the House's recently passed health care bill, here's how MSAs would function:

- The account must be linked to the purchase of a high-deductible health insurance policy with minimum deductibles of $1,500 for individuals, and $3,000 for families.

- Employers or employees could contribute, but the annual contribution could be no higher than $2,000/$4,000 (indexed for inflation) for an individual/family.

- Contributions and interest earnings would be fully deductible for tax purposes.

- Withdrawals must be only for those health purposes as defined in the Internal Revenue Code (which include insurance for long-term care, COBRA coverage, and health expenses while unemployed) or they would be subject to tax and penalty.

- Withdrawals for purposes other than those for health purposes in the Internal Revenue Code (I.R.C.) would be taxed and subject to a 10-percent penalty (unless the beneficiary had reached age 59 ½, was disabled, or had died).

The Operation of MSAs: No "Use or Lose" Rule

The proposed MSAs would operate similarly to two other precedents — the aforementioned IRAs and so-called "flexible spending accounts," or FSAs. FSAs are employer-administered accounts that allow employees the choice of distributing wages between cash (taxable) and health or dependent care (non-taxable). Because of the flexibility they give to workers, FSAs have been popular components in the workplace since the 1980s with over 50 percent of state and local, and large- and medium-size company employees having the opportunity to participate. However, there is a very significant difference between FSAs and the proposed MSAs: FSA money not used at year's end is forfeited because of the "use-or-lose" rule under the tax code.

The IRA has favorable tax treatment and carry-over capability. These two IRA elements create an incentive to invest and to use the contributions wisely. In contrast, FSAs' "use-or-lose" factor encourages participants to under-invest at the front-end and to indiscriminantly "dump" remaining money at year-end, regardless of need.

The MSA proposal would combine the strengths of the IRA and FSA. It would allow for the flexibility and constant use of FSAs, and the favorable tax treatment and carry-over capability of IRAs.

Evidence of the Popularity of MSAs

MSAs have wide support throughout the nation. Over half the states either have passed or are working on MSA legislation granting them favorable tax treatment, and it is estimated that

3,000 companies offer them in some form to their employees. Even the United Mine Workers union offers them to its members.

- As of last year, 17 states had passed MSA laws: Arizona, Colorado, Idaho, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, New Mexico, Oklahoma, Utah, Virginia, Washington, and West Virginia.

- An additional 11 states have called on Congress to enact MSA legislation.

- And, 11 states are currently considering MSA legislation.

The potential popularity of MSAs is great. A recent Blue Cross-Blue Shield survey found that 67 percent of employers were interested in offering them and that 43 percent of employees stated that they would likely choose an MSA over their current plan.

MSAs Offer Maximum Health Care Flexibility

MSAs are such an attractive option because they offer maximum health care flexibility. That flexibility translates into savings — for the employer, the employee, and the nation as a whole in the form of increasing the savings rate.

A recent study by Michael Bond, Brian Heshizer, and Mary Hrivnak of Cleveland State University offers good evidence of these savings. The study examined 27 Ohio firms of less than 200 employees that offered MSAs. The results were then compared to traditional health plans offered by these firms. The study found:

- On average, employees had lower out-of-pocket costs under MSAs than under the traditional plan. The average potential decrease was $317 for individuals and $1,355 for families.

- Employers saved as well, on average about 12 percent more than they would have from their traditional plans, with potential savings reaching as high as 34 percent — without increasing the potential out-of-pocket cost to employees.

Savings Come From More Efficient Use of the Health Care Dollar

How can such savings accrue to both employee and employer? The reason lies in the shortcomings of traditional health care insurance packages. No matter how individually tailored the traditional package is, it still relies on economies of scale — offering standardized benefits to a relatively large population. These still entail significant administrative costs and inefficiency (in the sense that an individual still winds up paying for services he or she does not use). Traditional health plans therefore cannot match the virtually unique aspect of the MSA, which

allows the individual to use not only as much health care as the individual needs but exactly the kind of health care the individual needs.

The "use-or-lose" incentive that is explicit to the FSA is implicitly endemic to traditional health insurance. Because the insured are paying a flat premium, the rational incentive is to get as much use as possible from it, so that it resembles a kind of health care buffet. Thus, there is little incentive for the efficient use of the health care dollar. The MSA concept removes that "use-or-lose" condition and so health care is used as it is needed and unnecessary demand is removed — effectively functioning as an a-la-carte plan. The net effect is to hold down the overall cost— ***and this will not only affect those directly making the expenditures, but will also affect the rest of the consumer market whose health care premiums are based partly on price expectations from overall demand: increasing overall demand increasing overall premiums.***

Other factors are important to the overall savings. For one, the proposed MSA structure would encourage personal savings over an extended period, similar to the IRA. This is because of the favorable tax treatment and penalty for misuse. The combined effect is significant, as demonstrated by an article in the *Journal of American Health Policy* (May/June 1994). Health economists Gail A. Jensen and Robert J. Morlock surveyed approximately 1 million individuals in 1989. Here are their results: one-third filed no claim; 73 percent filed claims between $0 and $500; and 89 percent filed claims of less than $2,000. If these individuals had MSAs like those currently proposed, the results could look like this (for individuals contributing the maximum $2,000 annually):

- Assuming average annual expenses of $250, the MSA would hold $9,821 after five years and $647,010 after 45 years.

- With average expenses of $1,000, the MSA would hold $5,068 after five years and $333,941 at retirement.

MSAs Wrongly Criticized for "Adverse Selection"

In spite of the demonstrable advantages, MSA's critics remain. They can be broken down into two groups: those who genuinely do not understand them, and those who disingenuously want to make them a partisan issue. Among both groups, the most common criticism is that MSAs will appeal mostly to the healthy and wealthy, drawing these people who have fewer health expenses and greater resources from the traditional insurance pool, and thus raising rates for the relatively sicker individuals that remain.

The charge that healthy and wealthy individuals should have a "market preference" for MSAs that is greater than comparatively less healthy and wealthy individuals — misnamed "adverse selection" by MSA critics — has not been borne out where MSAs have been used. Further, recall that the consumer market's health care premiums are based partly on overall

demand expectations, and so to the degree costs go down by MSA users, savings will be realized by the universe of health care consumers.

Returning to the earlier mentioned Cleveland State University study, these are the results of the comparison between the MSA and the traditional health care insurance costs using the actual figures from 27 small Ohio firms that further demonstrate why the "adverse selection" charge is wrong:

TRADITIONAL PLAN COSTS

	Deductible	Co-payment	Total
Individual	$300	$660	$960
Family	$744	$1,444	$2,188

MSA COSTS

	Deductible	Employer MSA Contribution	Total
Individual	$1,500	-$857	$643
Family	$2,000	-$1,167	$833

DIFFERENCE: MSA vs. TRADITIONAL PLAN

	Savings
Individual	$317
Family	$1,355

- Under the MSAs, both individuals and families had to spend less in order to reach full reimbursement from their respective health insurance.

- For the relatively healthy — those spending less than the MSA employer contribution — they retained every dollar saved in their account.

- The relatively sicker — those who would spend beyond their deductible — gained as well because it took fewer dollars ($317 and $1,355 respectively) to reach the full reimbursement rate.

- While practices can differ, the fundamental theory does not: MSAs offer both the relatively healthy and the relatively sick, significant savings opportunity.

Even if the relatively healthy are not unfairly favored, are the wealthy? No.

- According to a March 28, 1996 Joint Committee on Taxation analysis, almost nine out of every ten dollars in tax benefits would go to middle-class or lower incomes.

  — 88 percent of the MSA tax benefits would go to those making under $100,000.

  — 78 percent of the MSA tax benefits would go to those making under $75,000.

If the relatively healthy and wealthy are not favored by MSAs, would the relatively less poor still be hurt? No.

- Under the MSA approach, the low-income individual gets full "first-dollar subsidy" on all expenses up to the MSA contribution level.

- This contrasts with traditional health insurance where copayments continue for some time ($660/$1,444 for individuals/families in the above example).

- Such full first-dollar coverage will have the greatest attraction for the less wealthy for whom copayments can become a significant expense over the course of the year.

Why the Partisan Criticism, Now?

MSAs did not become a partisan issue until recently. Prior to that, they received widespread support across the political spectrum.

- At the state level MSAs have been passed by legislatures and signed by governors of both major parties.

  — In every state that passed MSAs, the bills passed with overwhelming majorities.

  — In five states, MSAs passed both chambers unanimously.

  — In three states MSAs, passed at least one chamber unanimously.

- In Washington D.C., President Clinton's party has often taken the lead on MSAs.

  — Senator Breaux (D-LA) introduced a bipartisan MSA bill in 1992, the "Medical Cost Containment Act of 1992."

    — Senators Daschle (D-SD), Nunn (D-GA), Dixon (D-IL), and Boren (D-OK) co-sponsored the 1992 bill.

    — These four senators in September of 1992 signed a "Dear Colleague" that stated: "We have introduced legislation that will begin to get medical spending under control by giving individual consumers a larger stake in spending decisions . . . the Medical Cost Containment Act of 1992 (S. 2873) . . . would allow employers to provide their employees with an annual allowance in a Medical Care Savings Account to pay for routine health care needs."

— The Senators stated their rationale: *"Today, even commonly required small dollar deductibles (typically $250 to $500) create a hardship for the financially stressed individual or family seeking regular, preventive care services.* ***With Medical Care Savings Accounts, however, that same individual or family would have this critical money in their account to pay for the needed services."*** The Senators recognized that the full first-dollar coverage of the MSA will encourage individuals to obtain medical care based on need, rather than on the deductible.

— The same bill was introduced in the House by Rep. Andy Jacobs (D-IN) and co-sponsored by 26 others in his party.

— Senator Simon introduced a MSA bill in 1994.

—- Then House Majority Leader Dick Gephardt included MSAs in his 1994 House leadership health care bill. He called MSAs "an idea the Ways & Means Committee has worked on for three or four years. It's very popular. A lot of people like that option . . . I think it's a great option." [Rep. Gephardt, *Equal Time*, CNBC, 8/2/94].

— In 1994, all but one member of Gephardt's party on Ways & Means voted to include MSAs in the Clinton health care plan.

— Just this year, four members of the President's party on the House Ways & Means committee voted for the package that included MSAs.

— As Rep. Andy Jacobs (D-IN), Rep. Bill Lipinski (D-IL), and Rep. Glenn Poshard (D-IL) point out in their 3/27/96 "Dear Colleague:" *"Medical Savings Accounts should not be a partisan issue. Please note: Democrats were the initial sponsors of MSAs . . . Health reform is too important to allow the posturing of a few to kill it."*

Both parties are on record for supporting the inclusion of MSAs "in any health reform bill passed by the Senate." Such language is contained in the Kassebaum/Kennedy health reform legislation.

— *"It is the sense of the Committee on Labor and Human Resources of the Senate that the establishment of medical savings accounts . . . be encouraged as part of any health insurance reform legislation passed by the Senate through the use of tax incentives relating to contributions to the income growth of and the qualified use of such accounts."* [S. 1028, the Kassebaum-Kennedy bill]

— Such language was included in Senator Kennedy's 1994 health care bill, S. 2296 — the Clinton-Kennedy health care bill: *"It is the sense of the Committee on Labor and Human Resources of the Senate that provisions encouraging the*

establishment of medical savings accounts be included in any health reform bill passed by the Senate. . . "

- President Clinton just last week called for an expanded use of IRAs to pay for certain health care expenses: *"[T]o put their savings into a retirement account that could be withdrawn from, tax-free, if there's a family emergency, if it's necessary for the health of a parent, or the health of a child . . . "*[President Clinton, 4/11/96 announcement on retirement proposals].

MSAs: Proven Portability and Flexibility

Medical Savings Accounts embody the goals that the Kassebaum-Kennedy bill set for itself. They are completely portable because they belong to the individual — not to an employer, not to an insurance company, and not to the government. MSAs are proven portability and flexibility in health care.

However, in Washington today, the "M" in MSAs has come to stand for "misconstrued." The current MSA proposal is neither radical nor untested. MSAs build on both practical experience and well-known concepts, more so than, say, the group-to-individual portability provisions contained in the Kassebaum-Kennedy bill.

- The MSA is in use in 17 states, by 3,000 businesses, and by state and local governments.

- MSAs do not favor the healthy or the wealthy, but they do favorably affect the lowest wage earners.

  — In cases where MSAs were actually used, "adverse selection" has not taken place.

  — A 3/28/96 Joint Committee on Taxation study shows that nine out of ten dollars of tax benefits would go to the middle and working class.

  — There is a real possibility that employers who could not afford conventional coverage (and where the less affluent are more likely to work) would make contributions to MSAs.

- Like, IRAs for retirement and FSAs for employee benefits, MSAs are individually-administered accounts.

- MSAs allow the individual choice and flexibility.

  — No one is required to either offer one or accept one.

  — If chosen, it allows an individual to uniquely tailor his health care to his needs, including his own time frame.

- MSAs are popular, both where they have actually been offered and where they have been suggested. Surveys have shown that both employers and employees would like the opportunity to have them.

- Many of the people who think that MSAs are a bad idea thought that "Clinton-care" was a good idea. It is not surprising that the people who thought the government should control health care think that the individual should not.

- MSAs are supported in S. 1028 itself, just as they were in the Kennedy-Clinton health care bill in 1994.

- Leaders in the President's party, including Minority Leader Daschle and House Minority Leader Gephardt have supported MSAs.

- President Clinton supports allowing individuals to use money from an individual retirement account for certain medical expenses.

- Finally, MSAs offer the possible collateral benefits of increasing the national savings rate, and decreasing overall health care premiums by eliminating unneeded services.

The current MSA proposal reduces the complex health care debate to a level everyone can understand. It raises the fundamental questions:

- Should families and individuals have MSAs as an option in health care?
- Should families and individuals have the right to make their own health care decisions?
- Should families and individuals have piece of mind of absolute portability of their health care?
- Should families and individuals have the right to greater flexibility in their health care?
- Should families and individuals have greater access to the full range of health care options?
- Should families and individuals have the right to tax deductions for saving for medical emergencies?

MSA supporters say "yes"; MSA opponents say "no."

Staff Contact: Dr. J.T. Young, 224-2946